VAC TRAK

Office Use Only

VacTrAK Support
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Alaska Immunization Program
3601 C Street, Suite 540
Anchorage Alaska 99503

Section 1: Provider Usage Agreement

This form is to be completed by the facility's designated VacTrAK administrator

The Alaska Division of Public Health (DPH) has established VacTrAK to provide a confidential, computerized system to maintain consolidated immunization records for Alaskans of all ages. Access to VacTrAK is permitted (1) for the sole purpose of providing information and documentation required to provide immunization services and (2) under terms and conditions prescribed by DPH. DPH reserves the right to revoke a user's access privileges at any time.

Please read the following statements. If you agree to abide by these terms, please complete the information requested below. Return the signed agreement to DPH at the address shown above.

On behalf of my health care facility or organization, I accept and agree to the following:

1. I/we will handle information or documents obtained through VacTrAK in a confidential manner.
2. I/we will restrict use of VacTrAK to accessing information and generating documentation only as necessary to properly conduct the administration and management of my immunization-related duties.
3. I/we understand that all VacTrAK transactions are logged and are subject to audit for quality assurance purposes.
4. I/we will not furnish information or documentation obtained through VacTrAK to unauthorized individuals for personal use, nor to any individuals not directly involved with the conduct of duties as they relate to immunizations. I understand that I may share this information with the patient or the patient's parent or guardian.
5. I/we will not falsify any document or data obtained through VacTrAK.
6. I/we will not attempt to copy in any unauthorized fashion all or part of the VacTrAK database or the software used to access the VacTrAK database.
7. I/we will carefully safeguard information relating to my/our VacTrAK access privileges and password and will not permit their use by any other person.
8. I/we will report any perceived threat to or violation of VacTrAK security to DPH.

Please print the full name of all staff members in your facility who will access VacTrAK and designate their requested privileges for querying and/or entering immunization data.

- **View Privilege** - Read-only access
- **Edit Privilege** - Access to view, add, and modify patient immunization records

Name	Privilege		Name	Privilege
	□ View □ Edit			□ View □ Edit
	□ View □ Edit			□ View □ Edit
	□ View □ Edit			□ View □ Edit
	□ View □ Edit			□ View □ Edit

(Additional names may be listed on a separate sheet.)

By signing below, I indicate that I have read and understand the security agreement shown above. I agree to comply with and enforce compliance of the stated provisions. Furthermore, I understand any violation of these provisions may result in termination of my access privileges and/or recommendation for prosecution.

I understand that I am responsible for the actions of the staff listed above. I am authorized by my supervisory position to accept such an agreement on behalf of my health care facility or organization.

_____

Facility Name

_____ _____

Facility Administrator for VacTrAK (please print) *Telephone Number*

_____ _____

Facility Administrator for VacTrAK (signature) *Date*

_____
Facility Name

Section 2: Enrollment Application

All facilities are required to complete this section.

Location Information *(please print or type):*

_____
Mailing Address Street or Post Office Box *City / Town / Village* *Zip Code*

_____
Physical Address Street *City / Town / Village* *Zip Code*

_____ _____
Phone Number *Fax Number*

_____ _____
Contact Name *Contact E-mail Address (required)*

Patient Information *(please print or type):*

Estimated number of patients in your practice / facility: Average number of patients seen:

_____ All patient records per day _____

_____ All active patient records per week _____

Are you a birthing facility? ____ Yes ____ No

If yes, average number of births per month: _____

_____
Facility Name

Section 3: Electronic Data Exchange

To be completed by facilities planning to exchange data with the VacTrAK electronically.

System Information *(please print or type)*

_____ _____ _____
Electronic Medical Record Software Name *Software Vendor* *Version*

Type of Software *(check all that apply)*	Length of time system has been in use		
	We have used the system for:	*or*	The system has not yet been installed, but we plan to begin using this system in:
☐ EMR / EHR	☐ ≤ 6 months ☐ 7 - 23 months ☐ ≥ 24 months		☐ ≤ 6 months ☐ 7 - 23 months ☐ ≥ 24 months
☐ Billing and Scheduling			
☐ Billing only			

Data Included

Data Fields	History of Disease	Historical Immunizations
Which of the following data fields are routinely collected? ☐ Lot number ☐ Manufacturer ☐ Expiration date ☐ VFC eligibility ☐ Opt-out of registry	Captured? ☐ Yes ☐ No If yes, where is it recorded in your system? ☐ Immunization module ☐ Elsewhere in EMR	Does your database contain dates for immunizations administered previously by other providers (i.e., historical immunizations)? ☐ Yes ☐ No If yes, how was it populated? ☐ Entered as patient appeared for visits ☐ Migrated from another system ☐ Scanned in

Data Exchange

Proposed Method of Exchange*	Type of Exchange	Codes	
		Which vaccine codes are used?	Who is responsible for code maintanance?
☐ One-Way ☐ Bi-Directional	☐ HL7 Realtime ☐ HL7 Batch ☐ Flat File	☐ CPT ☐ CVX ☐ NDC ☐ Don't know	☐ Vendor ☐ Provider ☐ Don't know

** One-way = To VacTrAK only*
Bi-directional = To VacTrAK and electronic return to your record system

_____
Facility Name

Technical Leaders

_____
Provider's On-Site Technical Leader

_____ _____ _____
Phone *Fax* *E-mail*

_____
Vendor's Off-Site Technical Leader (if applicable)

_____ _____ _____
Phone *Fax* *E-mail*

Please mail, fax, or e-mail this packet to the Alaska Immunization Program at the address below. If you have any questions, please do not hesitate to contact us.
Thank you for using VacTrAK!

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